TOWN OF MARSHFIELD
Board of Health
870 Moraine Street
Marshfield, MA 02050
781-834-5558 fax 781-837-6047
FOOD HANDLER PERMIT
APPLICATION FORM

Please complete, sign and return this form to the Health Department along with *FEE*, *State required Workers Compensation Insurance Affidavit form* and a *copy of current food certification(s).*
Months of operation____

Type of Permit: **Retail Food_____ Mobile____ Frozen Desserts____ Restaurant Food _____ "In House" Retail Food _____**
1 –25 seats _____ 25 – 50 seats _____ 50 – 100 seats _____ Over 100 seats _____ N/A____

PLEASE PRINT
Name of establishment_____
Name of Certified Professional Food Manager_____
(Please enclose a copy of Manager's certification)
Business address_____
Business Telephone #_____Fax # _____
Mailing address_____
(If different from above)
Hours of operation_____
Contact Person_____
Emergency Phone #_____Cell Phone #_____

Pursuant to M.G.L. Ch 62C, Sec.49A, I certify under penalties of perjury that I, to my best knowledge and belief, have filed state tax returns and paid all state taxes required under law. (Must be filled out and signed)

Signature of Individual or Corporate Name_____

By_____
Corporate Officer (If applicable)
If Corporation or partnerships, give name, title, and home address of officers or partners.

NAME TITLE HOME ADDRESS

Name & address
State of incorporation_____of local agent_____

I HEREBY STATE THAT ALL ANSWERS ARE CORRECT AND UNDERSTOOD OR HAVE BEEN CORRECTED.

Signature_____Date_____